MFP Sentinel Event Form

MFP Facilitator (OC, TC, PLA, CE): complete this form when an MFP participant experiences a sentinel event. An individual is considered an MFP participants if (s)he or their guardian has signed the *MFP Consent for Participation* form.

Date of Report: **Waiver CM/CC/SC Name:** **CM/CC/SC Phone:**

Participant First Name: **Participant Last Name:**

Participant Medicaid #: **Participant Date of Birth:**

Name & Address of Nursing Facility/Hospital/ICF Admitted to: (or n/a ☐):

Participant Address: **Participant City:** **State:** **Zip:**

Participant Phone Number: **Other Contact Name:** **Other Phone:**

Provider (if applicable):

Date of Incident:

Location of Occurrence:

Type of Sentinel Event: (Check only one)

☐ **Abuse,** ☐ **Neglect,** ☐ **Exploitation,** ☐ **Hospital/Nursing Facility/ICF Admit,**

☐ **Emergency Room Visit,** ☐ **Death,** ☐ **Involvement with Criminal Justice System,**

☐ **Medication Administration,**

☐ **Other (specify)** _____

Detailed summary of event:

Adverse outcomes related to the event: (Any injuries?) Describe in detail.

Witnesses to the event:

Action taken by MFP Facilitator at time of event (Discovery):

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MFP Facilitator Action Plan (Do): (What can be done by MFP Facilitator to prevent this from happening in the future?)

MFP Facilitator Process improvement (Check): (What MFP processes were instituted to evaluate the effectiveness of the action plan and reduce risk to the participant?)

Define follow-up time frames (Act/Monitor) for evaluating effectiveness of processes.

Notification:

	Name	**Date**	**Time**
MFP Facilitator Supervisor:			
Notified: ☐Yes ☐No			
Physician:			
Notified: ☐Yes ☐No			
Guardian/Family:			
Notified: ☐Yes ☐No			
DCH/MFP Office Staff:			
Notified: ☐Yes ☐No			
Other Agency Name:			
Notified: ☐Yes ☐No			
Other Agency Name:			
Notified: ☐Yes ☐No			

OC/TC/CE Name: Phone: Email:

OC/TC/CE Signature: _____ Date:

Notice: Send this completed *MFP Sentinel Event Form* to the DCH/MFP Office by secure email via File Transfer Protocol.